BACKGROUND - NON-RENEWAL REGULATORY and POLICY REQUIREMENTS

REGULATIONS

Non-renewal Notification to HCFA

Pursuant to 42 CFR 422.506(a)(3), HCFA will allow M+C organizations until July 1, to notify HCFA of its intent to non-renew its M+C contract with HCFA as of January 1, the following year. Also, M+C organizations are required to notify HCFA by July 1, of any plans to withdraw certain counties from the M+C's approved service area. Notifications to HCFA must be made in writing as required at 42 CFR 422.506(a)(2)(i).

M+C organizations that refuse to enter into a new contract with HCFA by July 1, and that fail to submit an ACRP by July 1, will be considered as having submitted a notice of non-renewal. Pursuant to 42 CFR 422.504(a)(4), revised BBRA Section 513, HCFA will not enter into a subsequent M+C contract for 2 years with the M+C organization. There is an exemption on the 2-year ban if there are no other plans in the county. Also, the 2-year ban does not apply to service area reductions.

M+COs that wish to reduce their service areas to include a partial county must submit that request to HCFA for approval, prior to the submission of their ACR on July 1. HCFA suggests that M+COs submit partial county SAR requests by June 1 to assure a decision in time for the M+CO to develop the appropriate ACR data.

Non-renewal Notification to Medicare Enrollees

Pursuant to 42 CFR 422.506(a)(2)(ii) the M+C organization must provide notice to their Medicare enrollees at least 90 days prior to the effective date of non-renewal. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative M+C plans, Medigap options, and original Medicare. This notice must receive HCFA approval.

Pursuant to 42 CFR 422.506(a)(2)(iii) the M+C organization must provide a notice to the general public at least 90 days before the effective date of non-renewal. This notice must be HCFA approved and published in one or more newspapers of general circulation in each community or county located in the M+C's service area.

BBA, Section 4031, makes amendments to Section 1882(s) of the Social Security Act to give Guaranteed Issue Medigap protections to 5 classes of Medicare enrollees that are subject to M+C organization non-renewals or service area reductions. Prior to BBRA, Guaranteed Issue Medigap protections had to be acted upon 63 days from the date of benefit coverage termination (end date of contract). BBRA, Section 501(a), modifies this Medigap protection. It gives Medicare M+C enrollees two choices. These choices are to access an alternative M+C plan and Medigap within 63 days of: (1) receiving notice from their M+C organization that their plan is leaving the program, or (2) when their coverage is terminated (end of contract).

Special Election Periods

Section 1851(e)(4) of the Social Security Act and regulations at 42 CFR 422.62(b) provide for Special Election Periods (SEPs) in certain situations. One such situation is when an individual's M+C plan has been terminated or discontinued in the service area in which the individual resides.

During a SEP, an individual may discontinue the election of M+C plan and change to a different M+C plan or the Original Medicare Plan. All M+C plans must accept elections during a SEP, unless a HCFA-approved capacity limit applies.

To allow members affected by non-renewals ample time to make a choice of their new election, the SEP for non-renewals generally begins when the M+C organization is required to give notification to the member and ends 3 months after that notification. For end of contract year non-renewals, the SEP begins on October 1 and ends on December 31. During this SEP, a beneficiary may choose an effective date of November 1, December 1, or January 1; however, the effective date may not be earlier than the date the new M+C organization receives the completed election form.

HCFA has the discretion to modify this SEP as necessary for any non-renewals or terminations when the circumstances are unique and warrant the need for a modified SEP. Refer to OPL 99.100 for a detailed discussion of SEPs.

POLICY

"Many Non-Renewal Policies that are described in this Non-Renewal SOP are detailed in current Operational Policy Letters (OPL), e.g., OPL 99.089-Contract Year 2000 Medicare+Choice Instructions. These policies are usually listed within the title of the OPL and/or are cited in the SOP. For example, more information on Marketing, Age-ins, Continuation of Enrollment, etc can be found in current OPLs. In order to keep this SOP current we are purposefully not citing individual OPLs since they may be updated or revised at any time.

Instructions for Notifying HCFA of Contract Non-renewals or Service Area Reductions

All M+COs that plan to non-renew a Medicare+Choice contract or reduce the service area of a plan MUST notify HCFA of its intention, in writing, no later than July 3, 2000. All notifications of non-renewals and requests for reducing service areas should be submitted to the attention of:

Mr. Gary Bailey
c/o Ms. Cheryl Bitoun
Health Plan Administration Group
Center for Health Plans and Providers
C4-23-07
7500 Security Blvd.
Baltimore, MD 21244-1850

A copy of this notice should be sent to the plan managers at the HCFA central office and regional office.

Notification Deadlines for Section 1876 Cost-Based Contractors

Section 1876 Cost contractors must provide notification of a nonrenewal decision or service area reduction request by October 2, 2000. Cost contractors may notify HCFA earlier than October 2. Detailed instructions for cost non-renewals will be provided at a later date.

Special Instructions for Partially Reducing County Service Area

HCFA continues to adhere to the Acounty integrity@ rule in accordance with OPL #90, AService Area Requirements for Medicare+Choice Coordinated Care Plans,@ April 23, 1999. Therefore, a request for reducing a service area in only part of a county must be reviewed and approved by HCFA before the county is included in the ACRP for CY 2001. **To allow HCFA sufficient time to review a partial county reduction request, organizations must submit their request to the appropriate HCFA regional office and send a copy to Cheryl Bitoun in Central Office no later than June 15, 2000**. If the request is approved, the partial county should be included in the ACRP for CY 2001. If the request is not approved and the organization wants to continue to serve the full county, the county should be included in the ACRP for CY 2001. If the request is not approved and the organization no longer wants to serve the full county, the organization should notify HCFA as soon as possible and should not include the county in the ACRP for CY 2001.

Each request for a partially reducing a county service area must provide a rationale for how it meets the exception criteria detailed in OPL #090. The rationale should contain the following: (a) an explanation of how the request relates to the commercial network in the proposed excluded area, (b) a description of other providers available in the proposed excluded area and the attempts made to establish contracts, (c) details about the variances in age, income, occupations, health status, and other factors that demonstrate differences or similarities between the area proposed for exclusion and the area that will remain, (d) a list of counties which you are

licensed by the state to do business and whether the state license pertains to commercial and Medicare.

Notice Requirements for Medicare Members Affected by Nonrenewals

HCFA is requesting that an interim letter be sent to beneficiaries to provide general information about the organization's nonrenewal. The interim letter has two versions, one of which is for beneficiaries who, on entitlement to Medicare, enrolled in an M+C organization AND who have been in M+C for less than 12 months. Individual beneficiary names should be inserted in the interim letter for 12-month beneficiaries, as they may need to show the letter to Medigap insurers as proof of their special rights and protections. The list of 12-month beneficiaries will be provided by HCFA with the acknowledgement letter.

M+COs that choose not to renew M+C contracts or choose to reduce service plan areas must send a notice of non-renewal to their Medicare enrollees by October 2, 2000, as required by 42 C.F.R. 422.506(2)(ii). HCFA will provide more detailed instructions about the requirements for notifying beneficiaries in a later communication.

Section 1876 Cost contractors who choose to non-renew their contracts must provide notification to Medicare beneficiaries by November 2, 2000. More detailed instructions regarding this requirement will be provided in a later communication.

Review of Beneficiary Letters and Notices

M+COs that choose not to renew contracts or choose to eliminate plan service areas effective January 1, 2001, should cease all marketing and open enrollment in these areas by September 1, 2000. HCFA strongly encourages, however, these organizations to suspend all marketing and open enrollment in areas in which they intend to discontinue services by July 3, 2000. In such circumstances, HCFA will waive the 30-day public notice required by 42 C.F.R. 422.111(d)(3). Organizations that suspend marketing and open enrollment as of July 3 may notify the general public of such actions at the same time. M+COs must continue to accept enrollments from individuals in their Initial Coverage Election Period (ICEP) and through Special Election Periods (SEPs) through November 30, 2000, for effective dates up to December 1, 2000.

If organizations that are not renewing contracts or that are reducing their service areas continue open enrollment between July 3 and August 10, or continue marketing, then marketing and enrollment election materials must contain a notice to prospective enrollees of the organization's decision to not renew or to reduce the service area. Regulations at 42 CFR 422.80(c)(1)(i) and (iv) require that M+COs adequately describe M+C plan rules as well as other information necessary to enable beneficiaries to make an informed decision about enrollment. M+C Organizations must prominently display attachments or addenda to current marketing materials, advertisements, and enrollment election forms that will alert potential members of the decision to not renew or to reduce the service area of the M+C contract, and the effect of the decision on enrollees in January 2001. The specific language for use in marketing materials for open enrollment is:

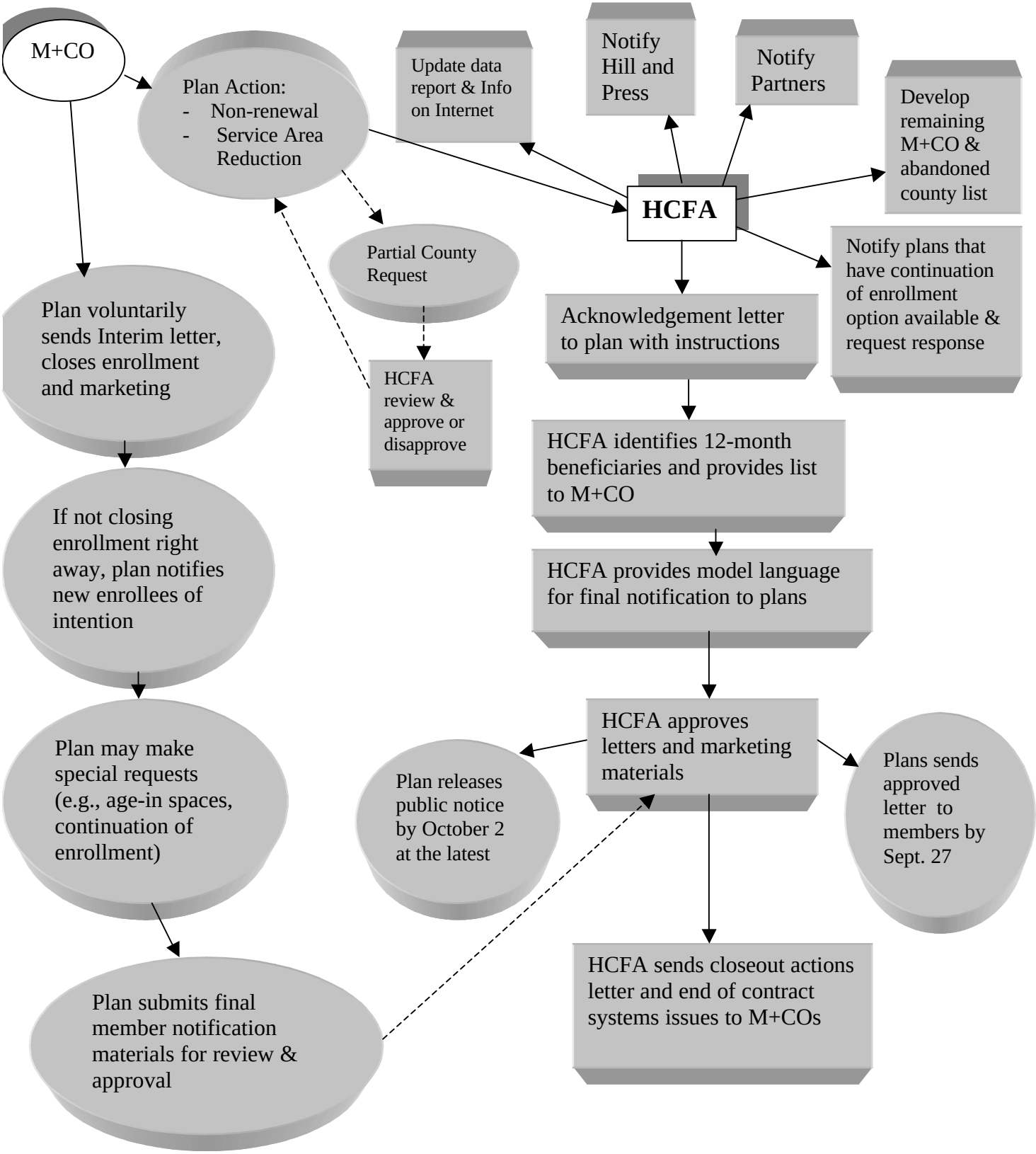
> "<insert plan name> will [(not be renewing its Medicare+Choice contract) or (will not be serving the following counties; <insert county names>)] effective January 1, 2xxx. You may choose to enroll in our plan through August 10, 2000, but your coverage will automatically end on December 31, 2xxx, (insert, if appropriate <if you reside in one of the counties we will not be serving>). If you do not enroll in another M+C plan effective January 1, 2xxx, you will be returned to Original Medicare on that date. You will receive additional information in October about your rights and additional options.

M+COs must continue to accept enrollments from individuals in their ICEP and through SEPs until November 30, 2000, for effective dates up to December 1, 2000. Marketing materials to these individuals must also announce the decision to nonrenew. Use the following language for marketing and enrollment materials for individuals in an ICEP or SEP:

> "<insert plan name> will [(not be renewing its Medicare+Choice contract) or (will not be serving the following counties; <insert county names>)] effective January 1, 2xxx. You may choose to enroll in our plan, but your coverage will automatically end on December 31, xxxx, (insert, if appropriate <if you reside in one of the counties we will not be serving>). If you do not enroll in another M+C plan effective January 1, 2xxx, you will be returned to Original Medicare on that date. You will receive additional information in October about your rights and additional options."

NOTE: The addendum to the marketing materials must be attached as soon as the M+CO receives the Acknowledgement Letter from HCFA. This statement must be included on all pre-enrollment and advertising related materials. Sales representatives must use this language in all presentations about the plan. If the model addendum above is used and affixed to materials that have been approved by HCFA, than the material does **not** require HCFA review or approval. However, if the addendum or marketing material is modified in any way, then the material (including the addendum) must be reviewed and approved by HCFA prior to dissemination.

MEDICARE + CHOICE
NON-RENEWAL & SERVICE AREA REDUCTION FLOWCHART



Medicare + Choice Non-Renewal Matrix

Due Date	Event	Lead Responsibility
May 1 through July 1	M+CO submits written, official notification to HCFA on Non-renewal. See Exhibit #1 for sample letter. (see also July 1 for acknowledgement)	Non-renewal Workgroup
May 1 through July 1	Update contact information (i.e. address lists) on Key Partners for all mailings.	RO, CBS
May 1 through July 1	HCFA will release information to Key Partners, and others as appropriate, as soon as possible	Non-renewal Workgroup
June 1	Update "State Specific" Medigap information	CMSO
June 1	Update of Non-renewal Information on the HCFA Website. • Qs & As • Fact Sheet • SOP	CO/CBS, Non-renewal Workgroup
June 1	Notify Key Partners of general non-renewal information and indicate when updates will be done to the HCFA websites. ❖ See Note at End of Matrix, page 28	RO, CBS
June 15	Partial County Service Area Reduction requests are due	Partial County PCT
No later than June 1	Start of focus testing of the Final Beneficiary Notification, if necessary • Review by CMSO/PHIG, CBS/SHIPS • External review by NAIC	CBS

Due Date	Event	Lead Responsibility
No later than July 1	Education of Regional Office CBS Branches, 1-800-MEDICARE Helpline representatives (i.e. Medicare Choices Helpline), REACH Train the Trainer Coordinators, and SHIPs (education by SHIP Team), Carrier/Intermediary Call Staff.	CBS, Non-renewal Workgroup
July 1 (If July 1 falls on a Saturday or Sunday, the deadline will be the next business day)	HCFA receives written "official" Notice from M+CO on July 1 (July 3rd in 2000) • Check the Notice - Is the notice a standard non-renewal notice, or are there any special requests included from the M+CO? • If Service Area Reduction, check the notice for request to offer continuation of enrollment to existing beneficiaries if M+CO is only M+CO in the specific county • Partial County SAR? Provide this to the Partial County PCT • Log Information onto HCFA database	CHPP/HPAG
As soon as possible after Non-renewal Notice received	HCFA issues acknowledgement letter to Non-renewing M+COs which includes general instructions to M+CO, information contained on the HCFA Web Site. See Exhibit #2 Acknowledgement will encourage M+CO to send Interim letter, close enrollment and cease marketing immediately. HCFA will identify those beneficiaries, who upon being eligible for Medicare, chose to enroll in an M+CO and are in their first 12 months of enrollment. These members receive a separate interim letter.	CHPP/HPAG
As soon as available after July 7	Listing of Specific M+COs that have elected to non-renew becomes Public Information and is posted on the HCFA website	CBS, Non-renewal Workgroup

Due Date	Event	Lead Responsibility
By end of July	HCFA will release detailed information on non-renewals. For example, comparisons and data on: • Part B only beneficiaries • ESRD beneficiaries • Listing of abandoned counties	HPAG, Non-renewal Workgroup
As soon as available after July 1	Communication to Medigap Insurers	CMSO
Approximately July 14	M+CO submits Interim Beneficiary Letter and Public Notice for Enrollment Closure. HCFA will review and approve. • Review variable language only in Exhibits #3 and #5a and 5b • Expedited review required • Tracking information sent to Non-renewal Workgroup • Copies of approved materials sent to CO Plan Manager	RO Plan Manager
July 15	Language for Model Final Beneficiary Notification Complete	CBS, CMSO
Approximately July 15	Package of Final Instructions completed, which includes: See Exhibit #7 • Model Final Beneficiary Notification Letter (Exhibit #9a – 9d) • List of remaining M+CO's and abandoned counties • Medigap Information	CO/CHPP
Approximately July 17	Mail Interim Notices and publish Public Notice (close enrollment and cease marketing)	M+CO

Due Date	Event	Lead Responsibility
July 20 through July 30	Assemble packages of Final Instructions for Non-renewing M+C.O.s. See Exhibit #7	CBS, Non-renewal Workgroup
July 26	Update NMEP Coordinating Committee with status of Non-renewal activities.	CBS, Non-renewal Workgroup
August 1	Mailing of Final Instructions to Non-renewing M+C.O.s	CO/CHPP
August 10	Last date of open enrollment and marketing prior to enrollment closure	NA
No later than August 25	M+CO submits Final Beneficiary Letter and Public Notice (if Public Notice not done earlier in the year) to HCFA for review and approval. • Exhibit #9 • Although this is an expedited review, this allows about 45 days prior to October 2 for review • Beneficiary Services will provide outreach activity information	M+CO RO/CBS
August 25 through September 15	Review and approval of Final Member Notification and Public Notice • Expedited review required. • Tracking information sent to Non-renewal Workgroup • Copies of final approved materials and approval sent to CO Plan Manager • Insert schedule of RO Outreach activities attachment	RO Plan Manager, RO/CBS
No later than September 1	Letter sent to Renewing M+COs to inform them of Special Election Period (SEP) (Ex. #8)	HPAG, Non-renewal Workgroup

Due Date	Event	Lead Responsibility
No later than September 1	For M+COs renewing their contract for the following year, approval of ACRs and PBP, Communication to M+COs, and R.O.s	HPAG/DPFE
No later than September 1	Expedited review of Marketing materials required for renewing M+COs in areas involving non-renewals.	RO Plan Manager
September 15	HCFA places next year's M+CO information on Medicare Compare website	CBS
September 15-October 1	Notification of Medigap insurers in impacted states.	CMSO
September 15 through October 15	Beneficiaries receive next year's M+CO information in Medicare and You Handbooks	CBS
September 27	Mailing of Final Beneficiary Notices	M+CO
ASAP after approval of Final Beneficiary Notification	HCFA sends final beneficiary notification to partners (SHIP, call center, etc.)	RO Plan Managers
October 1	Update NMEP Coordinating Committee of status of Non-renewal and September 15 information	CBS
October 1	Special Election Period begins for beneficiaries affected by Non-renewals.	NA

Due Date	Event	Lead Responsibility
October 2	The deadline for notification of Medicare Cost Plan renewal/non-Renewal is October 2.	NA
No later than October 2	Release copies of each M+CO "specific" Final Member Notification Letters to Regional Key Partners (i.e. SHIPS, etc.)	RO Plan Manager
October 2	The receipt by beneficiary of Final Member Notification starts the first of two 63-day Guaranteed Issue (GI) Medigap periods.	NA
No later than October 2	Release of Non-renewal Public Notice by Non-renewing M+COs. (If not already done with July closure of enrollment) Exhibit #3	M+CO
October 15	Regulatory Deadline for Renewing M+COs to notify Medicare+Choice members of next year's benefit and program changes.	M+CO
November	HCFA Lessons Learned meeting	Non-renewal Workgroup
November 1	Annual Open Enrollment starts	NA
No later than November 10	Cost Plan non-renewal information is posted on HCFA websites.	CHPP/CBS
November through December	HCFA issues Non-renewing M+COs "close out" information/instructions they must meet AFTER the end of their contract.	CHPP

Due Date	Event	Lead Responsibility
December 4	63-day period ends for the first Medigap guarantee issue period.	NA
January 1	Non-renewing M+CO's contract ends and this date starts the second 63 day Guaranteed Issue Medigap period	NA
March 4 (One day earlier if a leap year)	63 day period ends for Medigap guarantee issue	CMSO

❖ Information will be shared with Partners via the Internet and as needed through a contact system that includes:

The Non-renewal Workgroup, Central & Regional Offices, contacts: State Officials, Insurance Commissioners, State Medicaid Directors, Area Agencies on Aging, State Health Insurance Programs (SHIPs), PROs, Local Government Officials, key employer groups that provide Medicare managed care options to their retirees, State Chambers of Commerce, Local Government Agencies, SSA District Offices, Senior Counseling Agencies, regional AARP contacts, Fiscal Intermediaries, Carriers, the NMEP Partnership Alliance (the organizations are too numerous to list individually), ESRD networks, the 1-800-Medicare Call Centers, the REACH RO contacts, RO Medigap Coordinators and ASPE (if not part of Workgroup).

The Intergovernmental & Tribal Affairs Office contacts: Natl. Asso. Insurance Commissioners (NAIC), Natl. Asso. State Medicaid Directors (NASMD), Natl. Asso. State Units on Aging (NASUA), Natl. Asso. Counties (NACo), Natl. Conference of State Legislators (NCSL), Natl. Governors Asso. (NGA), Governor's Office, and State Legislators.

The Office of Legislation contacts: Congressional Offices in D.C. and appropriate Standing Committees

EXHIBITS – MODEL LETTERS

Exhibit #1 – Sample Non-renewal Letter for use by an M+C Organizations
Exhibit #2 – Sample Acknowledgement Letter
Exhibit #3 - Model Public Notice of Enrollment Closure for Non-renewing M+C Organizations
Exhibit #4 – Model Enrollment Denial Letter
Exhibit #5 – (a) Interim Letter
(b) Interim Letter for 12-month members
Exhibit #6 - Sample HCFA Approval Letter for use to Approve the Interim Letter and/or Public Notice
Exhibit #7 – HCFA's Non-Renewal Instructions to be Released Approximately August 1st
Exhibit #8 – Model Letter – Informing Remaining Plans of Non-renewal Activity in Area/SEP
Exhibit #9 – Draft Final Beneficiary Notification **(These letters are currently undergoing focus group testing)**
Exhibit #10 - HCFA's Approval Letter for Final Beneficiary Notice
Exhibit #11 – Sample Close-out Letter

Other Item – Lessons Learned

EXHIBIT #1

Mr. Gary Bailey
c/o Ms. Cheryl Bitoun
Health Plan Administration Group
Center for Health Plans and Providers
Mail stop: C4-23-07
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Bailey,
Subject: Non-renewal of contract effective January 01, 2001 for contract number <<PXXXXX, HXXXX>>

In accordance with 42 *CFR §422.506(a)(2), Non-renewal by an M+C organization*, <<ABC MCO>> is notifying HCFA of its intent to:

- **Nonrenew the entire contract; or**
- **Reduce the service areas for the following counties; or**
- **Reduce the service area for the following partial counties with zip codes**

The list of counties or partial counties with zip codes to be removed from contract include:

Our decision to nonrenew or reduce the above contract was based on the following reasons (optional):

In addition to the above contract activity, we are dropping the following lines of business (optional):

- **FEHBP**
- **Medicaid**
- **All Business lines**
- **Other**

If you have any questions, please contact _____ at <<Phone number>>.

Sincerely,

<<President/CEO>>, <<Signature Date>>
<<ABC HMO>>
<<Address where HCFA is to send non-renewal acknowledgement letter>>

EXHIBIT #2

SAMPLE ACKNOWLEDGMENT LETTER

Date:

TO: President/CEO of Medicare+Choice Organization (M+CO Name & H ####)

RE: Information on Contract Non-renewal or Reduction in Service Area

(Paragraph for contract non-renewal)
This letter is to acknowledge your letter dated **MM/DD/YY** to non-renew contract **(#H0000)** effective January1, 2001.

(Paragraph for Service Area Reduction)
This letter is to acknowledge your letter dated **MM/DD/YY** to reduce the service area of contract **(#H0000)** for the following counties effective January 1, 2001:

Because your decision affects Medicare beneficiaries, the Health Care Financing Administration (HCFA), and other critical parties, we want to work with you as partners to create a smooth and well-coordinated transition during this time. To that end, we want to inform you about HCFA's non-renewal process, and to ask for your cooperation in releasing timely information to all involved parties.

(Paragraph for Partial County Reduction Requests)
Your notice of non-renewal included a request for a partial county reduction in your current service area. This request has been forwarded to the Partial County Product Consistency Team. This team has the responsibility for review and approval of your request. If additional information is required to support your request, a team member will contact you.

***(Note:** a situation specific decision may be needed in order to determine whether or not an interim notice can be sent at the time of the acknowledgement letter)*

(Paragraph for Service Area Reduction in Abandoned Counties)
If your organization is reducing its M+C Plan service area in a county or counties where there are no other M+COs, you may elect to offer your affected members the option of continuing enrollment in the M+C Plan per BBRA Section 501(c). If you choose this option, you must submit your request to me in writing within one week of receiving the Non-renewal Instructions from HCFA, which include the list of remaining managed care options in each county. You should receive these instructions approximately August 1, 2000. We will work with you to develop an approved letter, which you may send to beneficiaries to notify them of their options.

HCFA intends to provide our partners with information regarding your notice of non-renewal as soon as possible after receipt of your notice. These partners include:

- Certain State agencies, such as the State Insurance Commissioner, State Medicaid

Department, and State Health Insurance Assistance Program (SHIP);
- Congress;
- Social Security Administration;
- Medicare contractors, including carriers and fiscal intermediaries;
- the Medicare Choices Helpline; and,
- National Medicare Education Program alliance network.

We have already distributed general information to our partners, through a set of Questions and Answers on Non-renewals and a Non-renewal Fact Sheet. Both documents address typical beneficiary questions on their rights and protections under Medicare. In an effort to help ensure that beneficiaries receive consistent and accurate information on non-renewals, we have enclosed a copy of these materials for use by your organization. Also, you may access the HCFA website at www.hcfa.gov or www.medicare.gov to obtain the most up to date materials on the non-renewal process.

In addition, you will need to do the following:

- Without any revisions, you may release the attached model letter(s) (Interim notice(s)) by **July 17, 2000,** to all beneficiaries affected by your decision to non-renew. If you have not revised the letter, please fax a **dated** copy of the letter you sent to enrollees to your Regional Office Plan Manager. If you plan to revise the letter, you must submit the letter to your Regional Office Plan Manager **prior** to release for approval. Although the law does not require the release of an "interim" letter, we believe it is important for beneficiaries to receive this information from you as soon as possible.

- **NOTE:** If we have determined that you have beneficiaries who joined a Medicare managed care plan when they first became eligible for Medicare and they are in their first year of enrollment, you will find a list of these beneficiaries attached to this letter and a second model Interim Notice which is to be sent specifically to them. These “12-month” beneficiaries have Medigap guaranteed issue rights that are different from other classes of M+CO members and need the specific information contained in the separate Interim Letter. You should run your own 12-month list and compare it to HCFA’s list, if there are discrepancies please contact Yolanda Robinson (410-786-7627) in Central Office. Please mail the specific Interim letter to your 12-month beneficiaries at the same time that you mail the Interim letter to your other members. Individual beneficiary names should be inserted in the Interim letter for 12-month beneficiaries, as they may need to show the letter to Medigap insurers as proof of their special rights and protections.

- You may choose to cease marketing on July 1, 2000, in the counties affected by your non-renewal decision or service area reduction. Also, you may choose to close enrollment effective with the date your public notice, which announces the enrollment closure, is published in the local newspapers. However, you must continue to accept enrollments from individuals in their initial coverage election period (ICEP) and through special election periods (SEPs) until November 30, 2000. Please contact your Regional Office Plan Manager with specific questions about enrollment closures. As with the "interim" letter, if you have

not made revisions to the model public notice, a copy of the notice which contains the date and names of publications, must be faxed to your Regional Office Plan Manager. If revisions are made, the public notice must be submitted prior to publication to the Regional Office for approval.

- If you choose to remain open for enrollment after July 1, your marketing materials must prominently announce your decision to non-renew the contract(s) or reduce the service area(s) to prospective members. This information must also be shared with any individual enrolling through an ICEP or SEP. However, for the efficient operation of the M+C program, you should cease marketing and open enrollment after August 10, 2000 so that all enrolled beneficiaries will be included in the mailing of the final notice. The following is an example of the language you may use as an attachment or addendum:

  > "<insert plan name> will [(not be renewing its Medicare+Choice contract) or (will not be serving the following counties; <insert county names>)] effective January 1, 2xxx. You may choose to enroll in our plan through August 10, 2000, but your coverage will automatically end on December 31, 2xxx, (insert, if appropriate <if you reside in one of the counties we will not be serving>). If you do not enroll in another M+C plan effective January 1, 2xxx, you will be returned to Original Medicare on that date. You will receive additional information in October about your rights and additional options.

You must continue to accept enrollments from individuals ICEPs and SEPs until November 30, 2000. Marketing and enrollment materials to these individuals must announce your decision to nonrenew. The following is an example of the language you may use in marketing and enrollment materials for individuals in their ICEP or SEP:

> ",<insert plan name> will [(not be renewing its Medicare+Choice contract) or (will not be serving the following counties; <insert county names>)] effective January 1, 2xxx. You may choose to enroll in our plan, but your coverage will automatically end on December 31, xxxx, (insert, if appropriate <if you reside in one of the counties we will not be serving>). If you do not enroll in another M+C plan effective January 1, 2xxx, you will be returned to Original Medicare on that date. You will receive additional information in October about your rights and additional options."

NOTE: The addendum to your marketing materials must be attached as soon as you receive this letter. This statement must be included on all pre-enrollment and advertising related materials. Sales representatives must use this language in all presentations about the plan. If you choose to use the model addendum above, and simply affix this to materials that have been approved by HCFA, than the material does **not** require HCFA review or approval. However, if you modify the addendum or marketing material in any way, then the material (including the addendum) must be reviewed and approved by HCFA prior to dissemination.

In closing, the law requires a final letter of non-renewal notification, approved by HCFA, to be sent to beneficiaries and contain information described in 42 CFR 422.506(a)(2). The final non-renewal notices must be mailed to enrollees by September 27 to ensure receipt by October 2, so that beneficiary notification will coincide with the regulatory requirements and the special election period that HCFA authorized for individuals impacted by non-renewals. For ICEP and SEP enrollments that occur after the mailing of the final beneficiary non-renewal notice, the notice should be provided with the confirmation of enrollment letter. In August, we will provide you with final non-renewal instructions, a final model beneficiary letter, Medigap information and remaining managed care choices. The general public notice, mandated by the same regulation, must be given at least 90 days prior to the end of the contract year, if you have not exercised this choice upon receipt of this letter.

Please contact your Central Office or Regional Office Plan Managers if you have any questions about the information in this notice.

Sincerely,

Gary A. Bailey
Director
Health Plan Administration Group

Attachments:

Model Public Notice
Interim Beneficiary Letter(s)
(List of 12-month Beneficiaries)
Q's & A's
Fact Sheet

cc: HCFA CO Plan Manager
HCFA RO Plan Manager

EXHIBIT #3

Model Public Notice of Enrollment Closure for Non-renewing M+CO Plans

The **<insert plan name>**, a Medicare+Choice HMO plan offered by **<insert M+CO name>** will stop participating in Medicare managed care at the end of 2000. If you are a current member, you may remain enrolled until December 31, 2000.

<insert this paragraph ONLY when publishing the notice in July>
All current members should wait for further information before you decide to change the way you receive your health care. You will receive an individual letter shortly, which will provide you with some important information. Also, in September you will receive information about other Medicare coverage options in the area.

For help and information about Medicare issues, we suggest you call <**insert M+CO telephone number and TTY number with operating hours**>. For additional information, please call the Medicare Choices Helpline at 1-800-633-4227, or the ---------- State Health Insurance Assistance Program (SHIP) on 1-800-XXX-XXXX/ TTY 1-800-XXX_XXXX with operating hours.

EXHIBIT #4

Model Denial of Enrollment Notice for Plan Withdrawals

Date:

Dear <**name of applicant**>:

<name of plan> is unable to accept your application for enrollment in because we have closed enrollment in your area. Effective January 1, 2000, <name of plan> will no longer participate in the Medicare program in <insert area or county if SAR>. Therefore, we are returning the application you submitted to <name of plan>.

We have attached a list of resources that are available to help answer your questions concerning Original Medicare and other options that may be available in your service area. If you or your spouse have health coverage through a former employer or union, contact your benefits representative before you make a health plan choice. If you have Medicaid coverage, contact the State Medical Assistance Office at **(XXX)XXX-XXXX**.

We thank you for your interest in <name of plan>, and we are sorry for any inconvenience this may cause you.

Sincerely,

EXHIBIT #5a

Interim Letter

Dear <insert beneficiary's name>

Effective January 1, 2001, <insert M+C plan name> will no longer offer Medicare health benefits to our Medicare members in <insert name of county>. <insert M+C plan name> is committed to providing health care services to its Medicare enrollees through December 31, 2000. You can remain enrolled in <insert M+C plan name> until December 31, 2000.

By October 2, 2000, you will get additional information from us about your health care options, including information about:

- other health plans that may be available to you, and
- the Original Medicare Plan and protections you have in choosing a Medigap insurance policy to supplement your Medicare benefits.

When you get this information, read it carefully -- please review the information and options available to you before you make any decisions. **And remember, no matter what decisions you make, you are still in the Medicare program**. We have attached a list of resources which are available to help answer your questions.

If you want to purchase a Medicare Supplement (Medigap) Insurance policy, you have 2 choices. You may:

- Stay in your plan until your coverage ends; OR
- Disenroll after you receive additional information from us in October about your health care options.

CAUTION: If you disenroll from <Insert M+C plan name> now, you may lose protections relating to your ability to purchase Medicare Supplement (Medigap) Insurance. For additional information regarding your Medigap rights and protections, please contact your <insert specific State or State Health Insurance Assistance Program name> at 1-800-XXX-XXXX.

We are committed to serving your health care needs through December 31, 2000. We have valued your membership with us, and we are sorry for any inconvenience this may

cause you. If you have any questions about this letter, you may call our member services department at (XXX) XXX-XXXX.

Sincerely,

Attachment 1

MEDICARE RESOURCES

1-800-MEDICARE
1-800-633-4227 and TTY 1-877-486-2048

Customer Service Representatives are available 8:00am to 4:30pm local time to answer questions about the Original Medicare Plan and provide up-to-date information regarding the managed care plans and private fee-for-service plans available in your area. You can also call this number if you want a copy of the *Medicare & You* handbook. The Handbook is available in English, Spanish, Braille, or on audiotape.

Other helpful publications available from 1-800-MEDICARE: *Understanding Your Medicare Choices, and the 2000 Guide to Health Insurance for People with Medicare.*

<insert specific State or SHIP program name> STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP) 1-800-XXX-XXXX

SHIP volunteers are available to discuss your individual situation and provide information on all options that are available to you.

ASSISTANCE FOR LOW-INCOME BENEFICIARIES

If you have low-income and limited resources, you may qualify for assistance with your Medicare premiums and deductible and coinsurance costs. Please contact your State or local office of Social and Health Services at XXX-XXX-XXXX for more information on what assistance may be available to you.

INTERNET SITE: WWW.MEDICARE.GOV

This website provides extensive information on the Medicare program including the text of the *Medicare & You* handbook and the *2000 Guide to Health Insurance for People with Medicare*. You can check the Medicare Compare database to see if any new managed care plans become available in your area in the future. Information regarding plan availability beginning January 1, 2001 will not be available until September 15, 2000. The website also lists referrals to local information sources and links to other health sites.

EXHIBIT #5b

Interim Letter for 12 month beneficiaries

Dear <insert beneficiary's name>

Effective January 1, 2001, <insert M+C plan name> will no longer offer Medicare health benefits to our Medicare members in <insert name of county>. You may be able to join another Medicare health plan or return to the Original Medicare Plan. By October 2, 2000, we will send you information about what options are available in your area and about your rights concerning Supplemental (Medigap) Insurance. Additionally, information about what Medicare health plans will be available in 2001 will be available on www.medicare.gov on September 15, 2000.

If you return to the Original Medicare Plan, you may be entitled to special Medigap protections. People who are in their first 12 months of Medicare health plan membership have special Medigap protections. Based on our records, you may be in one of two groups of individuals who are in the 12-month period.

Read the following information carefully.

- If within the past 12 months, you had a Medigap policy, in addition to Original Medicare, and you dropped this policy when you decided to try out a Medicare managed care plan, **you will be allowed to return to your old Medigap policy, if it is still available.** If your old policy is not available, you will have the choice of plans A, B, C, or F if available.

OR

- **If within the past 12 months, you joined a Medicare managed care plan when you first joined Medicare at age 65** you may purchase any Medigap plan, A – J.

In order to take advantage of these special options, you must act before your 12 month period expires or December 31, 2000 if earlier. Your 12-month period may end before December 31, 2000.

Important:
Because you are in this 12-month period, you must voluntarily disenroll before you are automatically disenrolled in order to exercise the broader Medigap choices that are available to you. Y**ou can disenroll at any time during your 12-month period.** You

do not have to wait until you receive the October letter to exercise these special Medigap rights.

Acting in time to exercise your rights simply means that you may have more Medigap choices. Remember, if you stay in your plan until December 31, 2000, you will still have the rights to Medigap protections; however, these rights are more limited.

If you decide to purchase a Medigap policy before you receive a letter in October, keep this letter as proof to your Medigap insurer that you may have these extra rights.

For additional information regarding your Medigap rights and protections, please contact your <insert specific State or State Health Insurance Assistance Program name> at 1-800-XXX-XXXX.

We are committed to serving your health care needs through December 31, 2000. We have valued your membership with us, and we are sorry for any inconvenience this may cause you. If you have any questions about this letter, you may call our member services department at (XXX) XXX-XXXX.

Sincerely,

Attachment 1

MEDICARE RESOURCES

1-800-MEDICARE
1-800-633-4227 and (TTY 1-877-486-2048)

Customer Service Representatives are available 8:00am to 4:30pm local time to answer questions about the Original Medicare Plan and provide up-to-date information regarding managed care plans and private fee-for-service plans available in your area. You can also call this number if you want a copy of the *Medicare & You* handbook. The Handbook is available in English, Spanish, Braille, or on audiotape.

Other helpful publications available from 1-800-MEDICARE include: *Understanding Your Medicare Choices, and the 2000 Guide to Health Insurance for People with Medicare.*

<insert specific State or SHIP program name> STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP) 1-800-XXX-XXXX

SHIP volunteers are available to discuss your individual situation and provide information on all options that are available to you.

ASSISTANCE FOR LOW-INCOME BENEFICIARIES

If you have low-income and limited resources, you may qualify for assistance with your Medicare premiums and deductible and coinsurance costs. Please contact your State or local office of Social and Health Services at XXX-XXX-XXXX for more information on what assistance may be available to you.

INTERNET SITE: WWW.MEDICARE.GOV

This website provides extensive information on the Medicare program including the text of the *Medicare & You* handbook and the *2000 Guide to Health Insurance for People with Medicare*. You can check the Medicare Compare database to see if any new managed care plans become available in your area in the future. Information regarding plan availability beginning January 1, 2001 will not be available until September 15, 2000. The website also lists referrals to local information sources and links to other health sites.

EXHIBIT #6

Sample HCFA Approval Letter for use to Approve the Interim Letter and/or Public Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
XXX Regional Office
Address
Fax (xxx) xxx-xxxx

July XX, 2000

Address

(H#)

Dear:

This letter is to confirm receipt and approval of your interim beneficiary letter. You may release the letter to your beneficiaries immediately. Please provide a copy of the letter, with the date of release, via facsimile to your Regional Office Plan Manager.

Also your proposed public notice has been approved with the understanding that you will cease open enrollment concurrently with the publication of the notice. Please provide a copy of the public notice, with the date and name of publications, via facsimile to your Regional Office Plan Manager.

<OR>

This letter is to confirm receipt and approval of your interim beneficiary letter with one modification. <[Xxxxx]> With this one correction, you may release the letter to your beneficiaries immediately. Please provide a copy of the letter, with the date of release, via facsimile to your Regional Office Plan Manager.

Please contact your Regional Office Plan Manager, if you have any questions.

Sincerely,

EXHIBIT #7

HCFA's Non-Renewal Instructions to be Released Approximately August 1st

DATE: August

TO: Presidents/CEOs of Medicare+Choice Contracts

RE: 2000 Operational Instructions for the Non-renewal of All or a Portion of a Medicare+Choice Contract

You notified the Health Care Financing Administration (HCFA) of your intent to non-renew all or a portion of your Medicare+Choice contract(s) effective December 31, 2000. The purpose of this letter is to provide final instructions on operational requirements for implementing this decision. **These instructions do not apply to Section 1876 Cost contracts.**

As Attachments to this letter, we have enclosed: (1) a set of instructions to assist you in the process of non-renewing all or a portion of your contract (Attachment 1 - Non-renewal Instructions), (2) a model notice of enrollment closure to be used for publication (Attachment 2 - Model Public Notice), (3) a list of the plans that are remaining in counties where your contract is terminating (Attachment 3 - List of Remaining Plans in Area), and (4) a Model Beneficiary Notice with Medigap information. The Model Beneficiary Notice will include all necessary information that needs to be provided to beneficiaries and we encourage you to use this notice to inform your enrollees of their rights.

There are important issues concerning beneficiary protections, systems requirements and remaining contract obligations to HCFA, of which you must be aware as you continue the non-renewal process. These issues are addressed in detail in the attached instructions and/or highlighted below.

Beneficiary Issues

- Your organization is required to notify Medicare beneficiaries of the obligations of issuers of Medicare supplemental policies under BBA requirements. Model language and Medigap information is provided in the Model Beneficiary Notice.

- Your organization may be responsible for costs incurred for Medicare beneficiaries hospitalized beyond the last day of the contract. If a Medicare beneficiary is hospitalized in a prospective payment system (PPS) hospital, your organization is responsible for all Part A inpatient hospital services until the beneficiary is discharged. For any other services, original Medicare or the next Medicare managed care organization that the beneficiary enrolls with will assume payment for Part B. If a Medicare beneficiary is in a non-PPS hospital, inpatient bills should be "split" in the following way. Your organization will pay the covered charges through the last day of the contract; original

Medicare or the next Medicare managed care organization will pay from the next day forward through the Medicare intermediary.

- Your organization should **cease open enrollment and marketing** by August 10, 2000 if it has not already done so. See the attached Model Public Notice for use in publicizing your enrollment closure. If you are currently enrolling new Medicare members, include these members in your mailing list so that they receive the final beneficiary notice of non-renewal.

Systems Issues

- **Non-renewed Contracts:** It is unnecessary for your organization to submit disenrollments for members who will remain in your organization through the end of the contract period because HCFA will conduct a mass disenrollment on December 31, 2000 for members remaining after all other transactions have been processed. You **must submit** disenrollments for members who wish to disenroll the 1st day of the last month of your contract, i.e., December 1, 2XXX.

- **Service Area Reductions:** Your organization **must** submit disenrollments for members in the area (counties) being nonrenewed.

  NOTE: Please follow the attached general instructions on Enrollment/ Disenrollment Systems Issues. In the early Fall your organization will also receive a separate communication with specific instructions from the Health Plan Payment and Operations Support Team (HPPOS).

A Non-renewing M+CO's Remaining Contract Obligations to HCFA

Your organization's remaining obligations to HCFA now that your Medicare+Choice contract is not renewed, is defined in regulations and operational policy letters.

Encounter Data: Section 42 CFR 422.257 requires all M+COs to submit encounter data to HCFA. This data will be used to calculate risk-adjusted payments to M+COs; therefore, HCFA must have all the required historical data for each beneficiary who has been enrolled in a Medicare managed care plan for this data to be accurate. Terminating contractors must continue to submit the required encounter data for services provided to all the organization's Medicare beneficiaries enrolled during calendar year 1999. All data submitted must be Year 2000 compliant.

Maintenance of Records: Section 42 CFR 422.502(d) requires M+COs to maintain and provide HCFA access to books, records, and other documents related to the operation of a Medicare+Choice contract. Medicare+Choice contractors are to maintain these records and allow HCFA access to them for six years.

Further information regarding HEDIS, CAHPs and Year 2000 requirements will be published during the Fall of 1999.

Process

After reviewing the information and instructions provided in this notice and verifying whether your State has particular requirements or instructions that must be included in these notices, you need to produce a Beneficiary Notice which includes all necessary information and submit that notice for HCFA's approval no later than August 25, 2000. After HCFA's approval, please release beneficiary letters on September 27, 2000 to ensure that the most current information is included and that beneficiaries receive notice by October 2, 2000. The letters must be dated October 2, 2000 to ensure consistency in applying the 63-day window of Medigap rights for beneficiaries.

A central office team and regional office plan managers will work together to coordinate all aspects of your non-renewal approval. Please see the specific instructions attached. Your regional office plan manager will answer any questions concerning this notice or process.

Sincerely,
/s/
Gary A. Bailey
Director
Health Plan Administration

Attachments:

1. Non-renewal Instructions
2. Model Public Notice
3. List of Remaining Plans in the Area
4. Model Beneficiary Final Letter

cc:

State Insurance Department
HCFA Regional Offices

Attachment 1

Non-Renewal Instructions

Beneficiary Notification

As addressed in HCFA's letter acknowledging receipt of your intent to non-renew all or a portion of your Medicare contract, a final notice must be sent to each Medicare enrollee. The law requires final non-renewal notices to be provided to enrollees by October 2, 2000. Also, we ask that you date these letters October 2, 2000, so that beneficiaries may use this date to apply the first of the two 63-day Guaranteed Issue Medigap periods. (The only exception to this is for ICEP and SEP enrollments that occur after September 27. Since you are required to accept ICEP and SEP enrollments through November 30, there may be a few cases where individuals are enrolled after the final beneficiary notices are mailed. In these cases, the final notice should be provided with the confirmation of enrollment letter, and should be dated accordingly.)

Since the law requires approval by HCFA of the final letter, we have provided model beneficiary notices on HCFA's Internet to expedite the review and approval process. Four versions are offered and should be used appropriately for the following members; (1) a general (non-abandoned county) letter for beneficiaries age 65 and over, (2) a letter for beneficiaries 65 and over in abandoned counties, (3) a general (non-abandoned county) letter for beneficiaries under 65, and (4) a letter for beneficiaries under 65 in abandoned counties . Using these models, you must submit a draft beneficiary letter no later than August 25, 2000 to allow enough time for HCFA's approval (by September 15) and your printing and mailing requirements.

Please note that in the beneficiary letter, you must notify members of all their available Medicare options. You may contact cost-based Medicare contractors that are accepting new members in your area and include them in your letter if they agree to be listed. You must contact the remaining contractors to determine whether or not they have an approved capacity limit. Please provide a facsimile of your proposed letter for approval to your Regional Office Plan Manager.

Note: Please contact the HCFA regional office prior to release of the Notice to obtain information on local beneficiary outreach activities and insert that information into the Medicare Resources Attachment of the Final Beneficiary Notice.

General Public Notification

If you have not already ceased open enrollment and marketing, you must do so after August 10, 2000. A public notice must be published in one or more newspapers of general circulation in each community or county in your contract area. A model public notice is provided for your use to expedite the review and approval process by HCFA. Using this model, you may submit a copy of the notice simultaneous with your submission for publication. If you are not using the model public notice you must submit a copy prior to publication for approval by HCFA. Submit the notice via facsimile to your Regional Office Plan Manager no later than August 25, 2000, if it

must be approved by HCFA prior to its publication. After publication, submit a dated copy of the publication, containing the name of the newspaper, to your Regional Office Plan Manager.

Important Medigap Information for Medicare Beneficiaries

Your organization must notify all Medicare beneficiaries, including the disabled and ESRD beneficiaries of the obligations of issuers of Medicare supplemental policies. A mandatory enclosure has been added as an attachment to the model beneficiary letter with the required language.

Enrollment/Disenrollment Systems Issues

Your organization must not submit enrollment requests received after the August10th enrollment cut-off date with enrollment effective dates any later than October , 2000, except for ICEP and SEP enrollments, which must be accepted through November 30, 2000. If new Medicare members are in the process of being enrolled, you must send them a letter informing them of the pending non-renewal. Since HPPOS will coordinate the systems aspects of your plan's non-renewal, it is essential that your organization follow these instructions to ensure a smooth transition for your Medicare members:

Systems Issues for Non-renewed Contracts

- Do not submit disenrollments for any members who will remain in your organization through the end of the Medicare contract period. During the last month of your contract, HCFA will conduct a mass disenrollment for all of your remaining plan members after all other normal transactions for all Medicare managed care organization have been processed. This will allow enrollment into other Medicare managed care organizations and will not interfere with any final month disenrollments you have submitted for processing. This is the best method to ensure that all members who do not enroll in another M+C organization are placed back into Original Medicare in a timely manner.

- Do submit disenrollments for members who have requested disenrollment for the first day of the last month of the contract period. Members are entitled by law to be disenrolled effective the first day of the month after the month in which you receive the request. Should some members request disenrollment effective the first day of the last month of your contract (i.e., 12/01/00), you are required to submit these disenrollments before or by the cutoff date in the last contract month. It is imperative that you do so, because during the mass disenrollment to be conducted by HCFA, all remaining Medicare members enrolled at the close of business on the last day of the contract will be removed as of that date (12/31/00). Therefore, please submit any final month deletions in accordance with the scheduled cut-off date for the final month of your contract.

You will not receive a reply listing report for the members who are disenrolled through the HCFA mass disenrollment. However, you will receive one for any transactions submitted by the cutoff date in the last contract month (12/X/2XXX) or any prior month.

Systems Issues for Service Area Reductions

For a service area reduction you must disenroll all members who reside in the terminated area or county. **It will be necessary for you to submit disenrollment records for all affected members no later than the cutoff date (12/x/2XXX) of the last operating month of the current contract.** You will receive a reply listing of all submitted transactions. You must review this report as soon as it is received, approximately the third week of December 2000, and verify the disenrollments for all submitted members. ***Your organization will receive a separate communication with specific systems instructions from the Health Plan Payment and Operations Support Team.***

If you have any questions about the enrollment/disenrollment/systems issues, please contact Jacquline Buise at (4l0) 786-7607.

HCFA Contact

If you have other questions related to the non-renewal of your Medicare contract, please contact your Regional Office Plan Manager. By following these instructions, your Medicare members will be provided a smooth transition from your organization to another option of health coverage.

MCO Contact

Please update your contract information in HCFA's systems prior to the end of your contract. This will allow HCFA to contact the appropriate person in your organization.

Attachment 2

Model Public Notice of Enrollment Closure for Non-renewing M+CO Plans

The **<insert plan name>**, a Medicare+Choice HMO plan offered by **<insert M+CO name>** will stop participating in Medicare managed care at the end of 2000. If you are a current member, you may remain enrolled until December 31, 2000.

For help and information about Medicare issues, we suggest you call <**insert M+CO telephone number and TTY number with operating hours**>. For additional information, please call the Medicare Choices Helpline at 1-800-633-4227, or the ---------- State Health Insurance Assistance Program (SHIP) on 1-800-XXX-XXXX/ TTY 1-800-XXX_XXXX with operating hours.

EXHIBIT #8

Model Letter – Informing Remaining Plans of Non-renewal Activity in Area/SEP

Effective December 31, 2000, the following M+C plan(s) in your service area will be non-renewing their contract with the Health Care Financing Administration (HCFA).

<[***list plan(s)***]>

This action creates a Special Election Period (SEP) for all impacted members. This SEP will occur from October 1, 2000 through December 31, 2000. Guidance on HCFA's policy regarding SEP's may be found in Operational Policy Letters (OPL) 99.098 and 99.100.

As stated in OPL 99.095, you can deny enrollment to eligible beneficiaries in the SEP only if you have reached a HCFA-approved capacity limit. As with other enrollment denials, a beneficiary should receive a written notice that an approved capacity limit prevents enrollment.

The final beneficiary letter will be sent to Medicare beneficiaries affected by a non-renewal in your service area, and will list your organization as an available M+C option. These members may request a November 1, 2000, December 1, 2000 or January 1, 2001 effective date in your organization. Of course, you must also accept all Medicare beneficiaries during the month of November, the period of Open Enrollment.

Thank you for your cooperation on this issue, and for your continued service to Medicare beneficiaries. If you have any questions or concerns regarding these instructions, feel free to contact your Regional Office plan manager.

Sincerely,

Gary A. Bailey
Director
Health Plan Purchasing and Administration

EXHIBIT #9

Final Beneficiary Letters are being Focus Tested

EXHIBIT #10

HCFA's Approval Letter for Final Beneficiary Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
Center for Health Plans and Providers
Health Plan Purchasing and Administration
7500 Security Boulevard
Baltimore, MD 21244
Fax (410) 786-8933

September X, 2000
Address

(H#)

Dear :

This letter confirms the approval of your final beneficiary notice that you previously submitted to HCFA for review. Please release this notice in time to ensure that the most current information is included and beneficiaries receive notice by October 2, 2000. If you have not already done so, please obtain information on local beneficiary outreach activities from your HCFA regional office prior to release of the Notice. Insert this information into the Medicare Resources Attachment of the Final Beneficiary Notice. On the day that you complete the mailing of your final beneficiary notice, please send a dated copy of your notice to HCFA as confirmation of this process. Send this copy to your regional office plan manager.

Capacity Limit Information

Please note, there may be plans in your service area that have been approved by HCFA for capacity limits (i.e. a plan will cease enrollment once the limit is reached). A beneficiary can establish if one of the plans in your area has been approved for and has reached capacity limits by contacting the plan directly. The Medicare Compare Internet site will be updated, monthly, to reflect capacity limit statistics.

If you have any questions concerning this letter, please call your Regional Office Plan Manager. Thank you.

Sincerely,

Cynthia Moreno
Director
Performance Review Team
Health Plan Administration Group

cc: Region,

EXHIBIT #11

Reminder /Close-out Letter

Dear Presidents/CEOs of Medicare+Choice (M+C) Organizations Not Continuing Their Participation in the M+C Coordinated Care Program or Reducing Their Service Areas Effective January 1, 2001:

Earlier this year, you notified the Health Care Financing Administration (HCFA) of your organization=s decision not to renew its M+C coordinated care plan contract, or to reduce its service area, for calendar year 2001. This letter is to inform you of your organization=s remaining obligations under sections 1851 through 1859 of the Social Security Act and implementing regulations at 42 CFR Part 422, your M+C coordinated care plan contract, and applicable operational policy letters.

Encounter Data: Section 1853 of the Social Security Act requires all M+C organizations to submit encounter data to HCFA. The statute requires organizations to submit inpatient hospital data for periods beginning on or after July 1, 1997 and data for other services beginning on or after July 1, 1998. HCFA=s requirements for submitting encounter data are stated in Operational Policy Letters (OPL) #64 and #70.

Under the BBA, this data will be used to calculate risk-adjusted payments to M+C organizations. For that data to be accurate, HCFA must have all the required historical data for each beneficiary who has been enrolled in a Medicare managed care plan. Therefore, contractors that do not renew their contract must continue to submit the required encounter data for services provided to all the organization=s Medicare beneficiaries enrolled during calendar year 2000 under the terms of the M+C contract. This includes the submission of the Certification of Encounter Data form, for the July 1, 2000 through December 31, 2000 period, as found in Attachment B of the M+C 2001 contract. Similarly, M+C organizations reducing their service areas must report encounter data for services provided during 2000 to enrollees in the service area not continued during contract year 2001.

Maintenance of Records: Medicare-contracting managed care organizations are required to maintain and provide HCFA access to books, records, and other documents related to the operation of a Medicare risk contract. Under 42 CFR 422.502(d) and (e), Medicare managed care contractors are to maintain these records, and allow HCFA access to them, for six years from the termination date of the contract or, in the case of service area reductions, the date from which service in a particular county was discontinued.

Continuation of Care: Managed care plans that do not renew their contract and those plans reducing their service areas may, in certain situations, be responsible for costs incurred for Medicare beneficiaries hospitalized beyond the last day of the contract. If a Medicare beneficiary is hospitalized in a prospective payment (PPS) hospital, your organization is responsible for all Part A inpatient hospital services until the beneficiary is discharged, as stated

in 42 CFR 422.502(g). Original Medicare or the beneficiary=s next Medicare-contracting managed care organization will assume payment for all services covered under Part B. If a Medicare beneficiary is in a non-PPS hospital, your organization is responsible for the covered charges through the last day of your contract or, for plans reducing their service areas, the last day in which service in a particular county was discontinued.

With respect to enrollees receiving care in a skilled nursing facility (SNF) upon the expiration of the 2000 contract, M+C organizations that do not renew their contract are financially liable for such care through December 31, 2000. After that date, Medicare beneficiaries continuing a SNF stay may receive coverage through either fee-for-service Medicare or enrollment in another M+C plan. Assuming that the SNF stay is Medicare covered, the number of days of the beneficiary=s SNF stay while enrolled in your plan will be counted toward the 100 day Medicare limit. For example, if a beneficiary in your plan entered a SNF on December 1, 2000 and was disenrolled on December 31, 2000, 31 days of the stay would be covered by your organization, leaving 69 days of fee-for-service coverage beginning January 1, 2001. Those beneficiaries who enroll in another M+C plan will receive SNF coverage beginning January 1, 2001 according to the HCFA-approved benefit package offered by that plan. M+C organizations reducing their service areas must apply this SNF coverage policy to their enrollees who reside in the discontinued portion of the service area.

Pending Appeals: Since the M+C contract and the regulations at 42 CFR 422.502(a)(3) require M+C organizations to provide access to benefits for the duration of their contracts, M+C organizations are obligated to process any appeals for services which, if originally approved, would have been provided or paid for while Medicare beneficiaries were enrolled in the plan.

Retroactive Payment Adjustments: For M+C organizations that do not renew their contract, once your contract has expired and your organization is no longer receiving payments from HCFA, your organization will still be required to reimburse HCFA for any overpayments. Also, your organization will still have the right to seek reimbursement from HCFA for any previously identified underpayments. M+C organizations seeking payment adjustments should report corrected information within 45 days from the date of your last HCFA reports to the Social Security Administration (for state/county code changes), the HCFA Regional Office, or the HCFA Central Office (for working aged adjustments). The reporting of corrected information to the appropriate office will trigger the HCFA retroactive payment adjustment process. The reported corrections will be verified and applied to your members= records. These corrections will be included as a part of your final payment reconciliation.

HCFA will complete final reconciliation of its accounts with your organization within approximately nine months of the termination date of your M+C contract. However, it is important to note that completion of final reconciliation may be delayed in the event your organization fails to comply with your remaining encounter data submission requirements.

For M+C organizations reducing their service areas, no final reconciliation is required. Payment adjustments related to coverage provided in the discontinued portions of the service

area will be conducted as part of the regular payment adjustment process to be conducted during the term of the Year 2001 M+C contract.

Health Plan Employer Data and Information Set (HEDIS): M+C organizations that do not renew their contract will not be required to submit during 2001 HEDIS measures based on their organization=s health care quality and services provided during contract year 2000. M+C organizations reducing their service areas will remain contractually obligated to submit HEDIS measures during 2001.

Thank you for your attention to these matters and for your participation in the Medicare managed care program. If you have any questions, please feel free to contact your Central Office plan manager.

Sincerely,

Gary A. Bailey
Director
Health Plan Administration Group

Cc:

CO Plan Manager
RO Plan Manager